Working Group for Healthcare Innovation
Meeting Minutes – Wednesday August 19, 2015
4:00pm – 6:00pm

Invited Working Group Members: Laura Adams, Edward Almon, Peter Andruszkiewicz, Mayor Scott Avedisian, Al Ayers, Dr. Timothy Babineau, Dr. Steven Brown, Albert Charbonneau, Dr. Jack Elias, Steven Farrell, Diana Franchitto, Louis Giancola, Hugh Hall, Jane Hayward, Steven Horowitz, Dennis Keefe, H. John Keimig, Dr. Dale Klatzker, Dr. Alan Kurose, Dr. Elizabeth Lange, Dr. E. Paul Larrat, Peter Marino, Linda McDonald, Rep. Joseph McNamara, Sen. Josh Miller, Dr. Alvaro Olivares, Sen. Juan Pichardo, Donna Policastro, Dr. Albert Puerini, Dr. Louis Rice, Dr. Pablo Rodriguez, James Roosevelt, Samuel Salganik, Lester Schindel, John Simmons, Rep. Joseph Solomon, Neil Steinberg, Dr. Robert Swift, Reginald Tucker-Seeley, Dr. Ira Wilson

I. **Welcome & Introductions – Secretary Roberts**

II. **Presentation Overview & Process by Secretary Roberts**– Presentation Available upon request via email to lauren.lapolla@ohhs.ri.gov and on the EOHHS web page.

III. **Presentation on Policies to Reduces the Growth on Medical Spending - Dr. David Cutler, Professor of Applied Economics, Harvard University** – Presentation available upon request via email to lauren.lapolla@ohhs.ri.gov and on the EOHHS web page.

Comments, Question, Discussion:
Ted Almon: You made reference to cost shift from public payer to private, but isn't it true that only public do any actual cost accounting, so why is there justification for cost shift?
Professor Cutler: Interesting question. I don't know that there is or isn't, but it is the reality of the situation. The state of Massachusetts has financed tough times by borrowing from the medical industry. Then when times were good, you raise rates in Medicaid or Medicare programs.
Ted Almon: Let me make an observation then that our hospitals accept the rates that unload their cost because of competitive pressures to do so, whereas we probably shouldn't do procedures we cannot make money on and should resend to places that can.
Professor Cutler: If you say, 'what have our providers done when they base this,' the most common things they are doing are: 1. Identifying persistent high cost users and truing to manage better. 2. Identifying who are people with behavioral health problems, and trying to treat the behavioral health problem better. 3. Avoiding unnecessary referrals to very advanced services, avoid unnecessary ER visits if urgent care may be opened later, avoid unnecessary hospitalizations, avoid discharge to a post-acute care facility if you can send them home. We think we can be

more efficient in how we operate the system, and so far we doing things that are productive– consistent with better care for patients.

Al Kurose: Blue Cross in Massachusetts has the ATC program with a high enrollment of primary care providers, and I hope you can help us understand that impact on a higher level - what impacts that kind of behavior when you also have a large payer offering another model.
Professor Cutler: Actually they are quite synergistic. When the state first began this, we had models that showed reduced spending, and due to those models the state backed off on punitive measures. Contracts were re-written in light of that to come in below targets. The target actually provides benchmark for negotiation, and I am told they have become much simpler between insurers and providers as you must know what the rate has to be.
Jim Roosevelt: I would say the starting point has become simpler.

Dennis Keefe: In RI we have more of a hard stop on contracting through OHIC. Curious about Medicaid and what you are doing in Massachusetts to manage the health care expense around Medicaid – still a choice issue in Mass – and beyond that, Medicaid managed care organizations etc.
Professor Cutler: We've had a couple attempt to try to address Medicaid. The first was the PCPR program, a bit like an ACO type model. That program was not as successful as we wanted it to be, not a lot of providers, etc., with a lot of upfront investment. In the interim, there were many more such programs around the state, and also the law changed with it being incumbent on mass health to set goals. This is a bit trickier with a Medicaid program than a commercial program as health needs are very different. Nonetheless, the state intends within the next 6-12 months to have a robust ACO like program. We run dually a program through MassHealth, and separately MCOS. Those MCOs are being pushed to enter into more value based payments.

Al Charbonneau: That impact has this had on premiums
Professor Cutler: Premiums have come down. Small business community big supporter of this. We had a move in Mass also into tiered products, the product increasing in popularity the most are those that take an expensive program and you have to pay more to go into that program.
Donna Policastro: Impressed with failures of care coordination numbers at 1%. Is there care coordination between states at all?
Professor Cutler: I believe when MA & RI each have a well-functioning Health Information Exchange we should work together in that way. At this time RI has a better functioning Health Information Exchange, and you may be waiting at the border for us.
Laura Adams: Quality system?
Professor Cutler: We have a robust quality measurement system, if anything have too many metrics and need to pare them down. If

anything, our numbers have gotten better through including these metrics in contracts and laws. Where I look for it is the chronically ill folks, those with SPI, with no surveys to see how they are doing but we hope these services would.

Kathryn Jervis: Is Mass working on all payers for quality?
Professor Cutler: About 30% of the dollars are on a performance basis, and we expect within a couple years will be about 60%. We have not yet set standards for what that means; reason being the literature has not developed enough to see what a good program is. There is a sense in which that number may be too high – a Worcester PCP patient may go to MGH with chest pains. MGH will be paid on an FFS basis for that patient. At one point talking about how rapidly to make this transition, and a leader of our health system said, I am a pediatrician and we are talking about how rapidly to pull the Band-Aid off the wound, and they said yes, and the response was well then do it rapidly.

Secretary Roberts: The process of developing the law and the target that the providers were on board with making it happen, I am interested that there wasn't pressure from some saying we are undercompensated, you can't do that; how did you get that broad sense of yes, we have to manage costs better.
Professor Cutler: There is a huge disparity in Massachusetts of the payment rates. The most famous chart was one that former AG Coakley put out on providers, looking at all almost the same or slightly up, and then Partners being sky high. Saying that rate regulation ought to be such that the highest payment capped at the 80th percentile and the lowest at the 20th percentile. Approximately half the providers liked it, and one of the providers disliked it. In the end, the high priced provider community said we will save money but you cannot do it by regulating our rates. We can get the money out, but let us do it in quantities not prices. There was lengthy discussion in the economics community if there was a thought that ultimately the rates would get compressed, and never had a full answer. It has prevented the rates from going further apart. In other ways, helped lower cost providers to addressing things: merger activities. Hasn't shown up in rates, rate structure looks much the same as it always did, but everyone has found a way so far to deal with it Like every state, we have too many hospitals and hospitals are closing. More will likely close.

Senator Miller: Regarding your slide that states "penalties are minimal" – would you say that in hindsight would prefer models that said tied penalties to missing the targets.
Professor Cutler: I don't know if I would have preferred those; in part that is not where the medical system in MA was – I think the real test will come as we think about the next couple of years.

Senator Miller: Should those models be more advisory, or have more authority in coming years in your opinion?
Professor Cutler: In general, I think having more teeth is good, but I hesitate as it doesn't work unless everyone agrees that it should work, that they are comfortable with it. From there you have an internal commitment. Most of the provider organizations think about the targets as they do things now. That is an overwhelming driver, has become that even though there is no obvious penalty.

Bob Swift: One of the statements of earlier, behavioral health patients bounce around a lot. Like Massachusetts, Rhode Island has a very fragmented Behavioral Health system. How is Massachusetts integrating health care services?
Professor Cutler: A very tricky issue, on top of that while Massachusetts has a greater supply of behavioral health providers than every state, we still do not have enough supply to meet demand. First, there is a bit of a grant program the state set up in this bill, taking money away from partners, a community program where big programs paid money to get this moving. There are particularly behavioral health folks in the Emergency Department. Beyond that, most of the providers are working on coordinating services in some way. One thing I would like us to do is the yellow area on the impact slide, taking out clinical waste, and streamlining care, by identifying the effective way to deal with them.

Al Charbonneau: I think it's appropriate that certain hospitals close, but often it is lower cost hospitals that are closing, so my question whether or not Massachusetts has addressed those issues?
Professor Cutler: I am not sure we have a better answer than any other state has to this. A lot of the consolidation is finding better ways to care for patients. We want to affiliate more with 'x' hospital in the community, get more patients here and better if could treat them there. One of the issues we don't feel we have the right answer to it.

Lee Rice: I have spoken to a provider in Massachusetts that went quickly to managed care, & realized he couldn't have a foot in both camps, that is a problem many face. What has all this done to access in Massachusetts, and to provider satisfaction?
Professor Cutler: There is now a lot of emphasis being put on the primary care clinicians, and the primary care clinician community is doing well. The clinicians who find this most difficult are those in small groups. A value based payment system in general is virtually impossible to do, that is where I would worry the most, but as part of a bigger practice they do very well. The ones who worry the most actually are the specialists. The access probably hasn't changed an enormous amount due to this, but did expand due to earlier legislation. More about other means of saving.

Unidentified commenter: Our new governor has some non-traditional views in this.
Professor Cutler: One of the things folks from outside healthcare wonder is why [healthcare] operates as poorly as it does. Very akin to say airplane safety – complicated, many pieces aren't used, etc. It doesn't surprise me that the Governor came in without a lengthy healthcare background is pushing for this change. Our Governor has a business background, and pushed much for transparency. Both are of the form this is a problem, get it solved.

Tina Spears: What role does it play on the consumer network?
Professor Cutler: Our commission does little on consumer protection, the state had much on office of patient protection; this particular commission is not incredibly regulatory. It is easy to conflate those and they are different things.
Tina Spears: When talking about tiered networks and disparities, is there a body in Massachusetts that looks at it specifically?
Professor Cutler: There is no body of government there that has the ability to do that. Private issue. Not a piece of legislation with punitive means.

Joan Kwiatkowski: To what extent are post-acute and community based care a part of this?
Professor Cutler: Quite a lot, and affiliations between post-acute and community providers are likely going to grow. Bounce back from post-acute providers is a problem, and then have strong relationships with those providers who have lower readmission to determine what is being done right. Community provider network is very important, many most interested in getting involved in the payment models if they can figure out how.

Reginald Tucker-Seeley: Are there efforts to track and monitor cost?
Professor Cutler: Not something the state regulates to great extent, we try to keep track of the access issue. Most of our employers want to avoid high cost sharing policies, so the cost sharing policies tend to make some providers more expensive. It is the case the only way you can get to Partners hospital is to be a part of the Partners health plan.

Beth Lange: Access cuts a few different ways, number of providers, but also high deductible co-pay plans, and what families have to pay does cut many ways. I think access issues are key, important data could be lost.
Professor Cutler: I encourage you all to think a lot about incentives for patients. Cost sharing is not going to go down in the US. It is not coming down, the question is what we can do to help people navigate the system in light of that.

Beth Marootian: Can you describe what malpractice reform looked like?
Professor Cutler: Massachusetts was never an extremely malpractice heavy state what it was, was more focused on the alternatives to going to litigation. Longer cooling off period, etc. Build a bit on the Michigan model. Interesting is the physician community wanted it and the legal community not heavily in favor, but were told if an agreement could be reached they would put it in legislation. Found a way to make it go smoother, rather than punish. And that is how it came about.

Al Ayers: Touching on the ideas of accountability on the person and compliance, I feel compliance would reduce the large waste pie chart.
Professor Cutler: To a great extent that is why cost sharing is going up, to encourage patients to be better consumers. What we know is that if you do studies on patients, many will say didn't understand the doctors instruction; others say they couldn't afford the Medicaid, still more distrust the pharmaceutical companies. One thing about this is that because of payment reforms, providers have incentive to get their patients to take meds.

IV. Public Comment: No additional public comment offered at this time.

V. Adjourn